DEPARTMENT OF MANAGED HEALTH CARE
HELP CENTER
DIVISION OF PLAN SURVEYS

TECHNICAL ASSISTANCE GUIDE

ACCESS AND AVAILABILITY OF SERVICES

ROUTINE DENTAL SURVEY

OF

HEALTH PLAN

DATE OF SURVEY:

PLAN COPY

Issuance of this March 17, 2011 Technical Assistance Guide renders all other versions obsolete.

DENTAL TAG

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H. Geographical Area Served.
Note: The applicant is required to demonstrate that, throughout the geographic regions designated as the plan's Service Area, a comprehensive range of primary, specialty, institutional and ancillary services are readily available at reasonable times to all enrollees and, to the extent feasible, that all services are readily accessible to all enrollees.
For the purpose of evaluating the geographic aspects of availability and accessibility, consideration will be given to the actual and projected enrollment of the plan based on the residence and place of work of enrollees within and, if applicable, outside the service area, including the individual and group enrollment projections furnished in Items CC, DD and EE of this application.
An applicant for plan license must demonstrate compliance with the accessibility requirement in each of the areas specified in paragraphs (i) through (iv) below, either by demonstrating compliance with the guideline specified in such paragraphs or, in the alternative, by presenting other information demonstrating compliance with reasonable accessibility. These guidelines apply only with respect to initial license applications and provide presumptively reasonable standards in the absence of actual operating experience. Such guidelines are not intended to express minimum standards of accessibility either for applicants or for licensees nor to create any inference that a plan, which does not meet these guidelines, does not meet the requirement of reasonable accessibility.

28 CCR 1300.67.2 (a) and (d)
Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees;
(a) The location of facilities providing the primary health care services of the plan shall be within reasonable proximity of the business or personal residences of enrollees, and so located as to not result in unreasonable barriers to accessibility.
(d) The ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably ensure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. There shall be approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees, or an alternative mechanism shall be provided by the plan to demonstrate an adequate ratio of physicians to enrollees.

28 CCR 1300.67.2.1 (b) and (c)(2), (3), and (9)
(b) If, in its review of a plan license application or a notice of material modification, the Department believes the accessibility standards set forth in Item H of Section 1300.51 and/or

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Section 1300.67.2 are insufficiently prescribed or articulated or are inappropriate given the facts and circumstances with regard to a portion of a plan's service area, the Department shall inform the plan that the Department will not allow application of those standards to that portion of the plan's service area. The Department shall also inform the plan of the Department's reasons for rejecting the application of those standards.
(c) The facts and circumstances to be included in a discussion of the reasons justifying the standards of accessibility proposed by the plan pursuant to subsection (a) or (b) of this section shall include, to the extent relevant, but shall not necessarily be limited to the following:
(1) whether the plan contract involved is a group health care service plan contract or an individual health care service plan contract;
(2) whether the plan contract is a full-service health care service plan contract or a specialized health care service plan contract, and if the latter, whether emergency services need not be covered;
(3) the uniqueness of the services to be offered;
(4) whether the portion of the service area involved is urban or rural;
(5) population density in the portion of the service area, including whether the service area is within a county with a population of 500,000 or fewer;
(6) whether, as of January 1, 2002, the county containing the service area had two or fewer full service health care service plans providing coverage to the entire county in the commercial market;
(7) the distribution of enrollees in the portion of the service area;
(8) the availability and distribution of primary care physicians;
(9) the availability and distribution of other types of providers;
(10) the existence of exclusive contracts in the provider community or other barriers to entry;
(11) patterns of practice in the portion of the service area;
(12) driving times;
(13) waiting times for appointments;
(14) whether the plan or any other health care service plan currently has significant operations in that portion of the service area; and
(15) other standards of accessibility that the Director deems necessary or appropriate in the public interest and consistent with the intent and purpose of the Act as applied to specific facts or circumstances.

28 CCR 1300.67.2.2. (c)(1)
(c) Standards for Timely Access to Care.
(1) Plans shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee’s condition consistent with good professional practice. Plans shall establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard.

28 CCR 1300.67.2.2. (c)(3)
(c) Standards for Timely Access to Care.

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(3) When it is necessary for a provider or an enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice, and consistent with the objectives of Section 1367.03 of the Act and the requirements of this section.

28 CCR 1300.67.2.2. (c)(4)
(c) Standards for Timely Access to Care.
(4) Interpreter services required by Section 1367.04 of the Act and Section 1300.67.04 of Title 28 shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment. This subsection does not modify the requirements established in Section 1300.67.04, or approved by the Department pursuant to Section 1300.67.04 for a plan's language assistance program.

28 CCR 1300.67.2.2. (c)(7)
(c) Standards for Timely Access to Care.
(7) Plans shall ensure they have sufficient numbers of contracted providers to maintain compliance with the standards established by this section.
(A) This section does not modify the requirements regarding provider-to-enrollee ratio or geographic accessibility established by Sections 1300.51, 1300.67.2 or 1300.67.2.1 of Title 28.
(B) A plan operating in a service area that has a shortage of one or more types of providers shall ensure timely access to covered health care services as required by this section, including applicable time-elapsed standards, by referring enrollees to, or, in the case of a preferred provider network, by assisting enrollees to locate, available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs. Plans shall arrange for the provision of specialty services from specialists outside the plan's contracted network if unavailable within the network, when medically necessary for the enrollee's condition. Enrollee costs for medically necessary referrals to non-network providers shall not exceed applicable co-payments, co-insurance and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider.

CA Health and Safety Code section 1367 (e)(1)
All services shall be readily available at reasonable times to each enrollee consistent with good professional practice. To the extent feasible, the plan shall make all services readily accessible to all enrollees consistent with section 1367.03.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Dental Director
- Director of Contracting/Provider Relations

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- QM Director

DOCUMENTS TO BE REVIEWED

- Policies and procedures that define the standards for the number and distribution of dentists within the service area
- Policies and procedures to periodically update/review the standards for the number and distribution of dentists within the service area
- Distribution service area maps indicating location and numbers of enrollees in comparison with dentists
- Plan primary health care access reports that provide information on provider distributions, closed practices and the like.
- Record of periodic review of the standards for the number and distribution of dentists within the service area, including minutes of relevant committee meetings (QM Committee, Public Policy Committee, etc.)
- Documents describing how the Plan monitors and ensures compliance with network standards.
- Corrective action plans for areas where access does not meet the standards
- Electronic version of the Plan's provider directory(s) and the link to the Plan's online directory(s).
- Review licensing filing of the Plan's access standards and confirm submission of appropriate policies and procedures.
- Review procedures for referring enrollees outside the contracted network, including but not limited to, policies and procedures, criteria for determining out of network referral, policy and procedures regarding applicable co-pays and co-insurance for enrollees accessing care out of network
- Referral Logs

Key Element 1:

1. The Plan has established a standard for geographic distribution of specialty/ dental care providers.
28 CCR 1300.51 (d)(H); 28 CCR 1300.67.2 (a) and (d); 28 CCR 1300.67.2.1 (b) and (c); 28 CCR 1300.67.2.2. (c)(1); 28 CCR 1300.67.2.2. (c)(7)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have an established standard on geographic distribution of specialty/dental care providers?			

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Key Element 2:

2. Can the Plan demonstrate that, throughout the geographic regions designated as the Plan's Service Area, a comprehensive range of specialty/dental services are readily available at reasonable times to all enrollees and, to the extent feasible, that all services are readily accessible to all enrollees.
28 CCR 1300.51 (d)(H); 28 CCR 1300.67.2 (a) and (d); 28 CCR 1300.67.2.1 (b) and (c); 28 CCR 1300.67.2.2.(c)(1); 28 CCR 1300.67.2.2.(c)(7)

Assessment Questions	Yes	No	N/A
2.1 Does the Plan have an established standard for the numbers of dental providers which is consistent with the enrollee population?			
2.2 Can the Plan demonstrate reasonable accessibility of dental services within all regions of the Plan's service area?			
2.3 Can the Plan demonstrate sufficient numbers of staff, professionals, administrative and support staff that reasonably ensures that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays?			
2.4 Is the Plan's provider network and demonstrated accessibility consistent with documents filed with the Division of Licensing?			

Key Element 3:

3. The Plan has established a mechanism that ensures that its health care services are readily available at reasonable times to each enrollee consistent with good professional practice.
28 CCR 1300.67.2.2. (c)(1); 28 CCR 1300.67.2.2. (c)(3); 28 CCR 1300.67.2.2. (c)(7); CA Health and Safety Code section 1367 (e)(1)

Assessment Questions	Yes	No	N/A
3.1 Does the Plan have mechanisms to ensure that its health care services are readily available at reasonable times to each enrollee consistent with good professional practice?			
3.2 If the Plan operates in a service area that has a shortage of Primary care dentists, does the Plan refer enrollees to or assist the enrollee to locate available and accessible contracted providers in neighboring service areas?			
3.3 Do the Plan appointment processes include prompt rescheduling of appointments in a manner appropriate for the enrollee health care needs?			

End of Requirement AA-001: Number and Distribution of Primary Care Providers

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Requirement AA-002: Number and Distribution of Specialists

STATUTORY/REGULATORY CITATIONS

28 CCR 1300.67.2 (d) and (e)
(d) The ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably assure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. There shall be at least one full-time equivalent physician to each one thousand two hundred (1,200) enrollees and there shall be approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees, or an alternative mechanism shall be provided by the plan to demonstrate an adequate ratio of physicians to enrollees;
(e) A plan shall provide accessibility to medically required specialists who are certified or eligible for certification by the appropriate specialty board, through staffing, contracting, or referral;

28 CCR 1300.67.2.1 (a)
Subject to subsections (a) and (b) of this section, a plan may rely, for the purposes of satisfying the requirements for geographic accessibility, on the standards of accessibility set forth in Item H of Section 1300.51 and in Section 1300.67.2.
(a) If, given the facts and circumstances with regard to any portion of its service area, a plan's standards of accessibility adopted pursuant to Item H of Section 1300.51 and/or Section 1300.67.2 are unreasonably restrictive, or the service area is within a county with a population of 500,000 or fewer, and is within a county that, as of January 1, 2002, has two or fewer full service health care service plans in the commercial market, the plan may propose alternative standards of accessibility for that portion of its service area. The plan shall do so by including such alternative standards in writing in its plan license application or in a notice of material modification. The plan shall also include a description of the reasons justifying the less restrictive standards based on those facts and circumstances. If the Department rejects the plan's proposal, the Department shall inform the plan of the Department's reason for doing so.

28 CCR 1300.67.2.2. (c)(1)
(c) Standards for Timely Access to Care.
(1) Plans shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee’s condition consistent with good professional practice. Plans shall establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard.

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28 CCR 1300.67.2.2. (c)(7)
(c) Standards for Timely Access to Care.
(7) Plans shall ensure they have sufficient numbers of contracted providers to maintain compliance with the standards established by this section.
(A) This section does not modify the requirements regarding provider-to-enrollee ratio or geographic accessibility established by Sections 1300.51, 1300.67.2 or 1300.67.2.1 of Title 28.
(B) A plan operating in a service area that has a shortage of one or more types of providers shall ensure timely access to covered health care services as required by this section, including applicable time-elapsed standards, by referring enrollees to, or, in the case of a preferred provider network, by assisting enrollees to locate, available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs. Plans shall arrange for the provision of specialty services from specialists outside the plan's contracted network if unavailable within the network, when medically necessary for the enrollee's condition. Enrollee costs for medically necessary referrals to non-network providers shall not exceed applicable co-payments, co-insurance and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider.

CA Health and Safety Code section 1345 (i)
(i)"Provider" means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Dental Director
- Director of Contracting/Provider Relations
- QM Director

DOCUMENTS TO BE REVIEWED

- Policies and procedures that define the standards for the number and distribution of specialists
- Policies and procedures to periodically review and update the standards for the number and distribution of specialists
- Record of periodic review of the standards for the number and distribution of specialists, including minutes of relevant committee meetings (QM Committee, Public Policy Committee, etc.)
- Documents that demonstrate how the Plan ensures that appropriate specialty services are available without delays detrimental to the health of the enrollees

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- Documents that demonstrate how the Plan defines high-volume specialists
- Documents that define the availability of specialty services (including the number or percentage of open practices)
- Summary referral data indicating number of referrals for each specialty within a given timeframe
- Plan specialist access reports and analysis
- Electronic version of the Plan's Provider Directory(s) and the link to the Plan's online directory(s).
- Review licensing filing of the Plan's access standards and confirm submission of appropriate policies and procedures.

Key Element 1:

1. The Plan has established a standard for the number of dentists within the service area. The standard provides for at least one full-time equivalent dentist to each 1,200 enrollees or the Plan may provide an alternative mechanism (i.e., via the filing of a material modification) to demonstrate an adequate ratio of dentist to enrollees. 28 CCR 1300.67.2 (d) and (e); 28 CCR 1300.67.2.2. (c)(1); 28 CCR 1300.67.2.2. (c)(7)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have an established standard on the ratio of dentists to enrollees?			
1.2 Does the Plan's standard provide for at least one dentist for each 1,200 enrollees?			
1.3 If "no," has the Plan established an alternative standard?			
1.4 If the Plan has established an alternative standard, has this standard been submitted to the Department via the filing of a material modification?			

Key Element 2:

2. The Plan has established a standard for the distribution of and accessibility to medically required specialists.
28 CCR 1300.67.2 (d) and (e); 28 CCR 1300.67.2.2. (c)(1); 28 CCR 1300.67.2.2 (c)(7)

Assessment Question	Yes	No	N/A
2.1 Does the Plan have an established standard on the distribution of and accessibility to specialists in its network?			

End of Requirement AA-002: Number and Distribution of Specialists

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Requirement AA-003: Hours of Operation and After Hours Service

STATUTORY/REGULATORY CITATIONS

28 CCR 1300.67.2 (d)
Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees;
(d) The ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably assure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. There shall be at least one full-time equivalent physician to each one thousand two hundred (1,200) enrollees and there shall be approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees, or an alternative mechanism shall be provided by the plan to demonstrate an adequate ratio of physicians to enrollees;

28 CCR 1300.67.2 (b) and (d)
Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees;
(b) Hours of operation and provision for after-hour services shall be reasonable;
(d) The ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably assure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. There shall be at least one full-time equivalent physician to each one thousand two hundred (1,200) enrollees and there shall be approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees, or an alternative mechanism shall be provided by the plan to demonstrate an adequate ratio of physicians to enrollees;

28 CCR 1300.67.2 (f)
(f) Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments;

28 CCR 1300.67.2.2. (c)(1)
(c) Standards for Timely Access to Care.
(1) Plans shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. Plans shall establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard.

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28 CCR 1300.67.2.2. (c)(7)
(c) Standards for Timely Access to Care.
(7) Plans shall ensure they have sufficient numbers of contracted providers to maintain compliance with the standards established by this section.
(A) This section does not modify the requirements regarding provider-to-enrollee ratio or geographic accessibility established by Sections 1300.51, 1300.67.2 or 1300.67.2.1 of Title 28.
(B) A plan operating in a service area that has a shortage of one or more types of providers shall ensure timely access to covered health care services as required by this section, including applicable time-elapsed standards, by referring enrollees to, or, in the case of a preferred provider network, by assisting enrollees to locate, available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs. Plans shall arrange for the provision of specialty services from specialists outside the plan's contracted network if unavailable within the network, when medically necessary for the enrollee's condition. Enrollee costs for medically necessary referrals to non-network providers shall not exceed applicable co-payments, co-insurance and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider.

28 CCR 1300.67.2.2. (c)(9)
(c) Standards for Timely Access to Care.
(9) Dental, vision, chiropractic, and acupuncture plans shall ensure that contracted providers employ an answering service or a telephone answering machine during non-business hours, which provide instructions regarding how enrollees may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency Dental, vision, chiropractic, and acupuncture plans shall ensure that contracted providers employ an answering service or a telephone answering machine during non-business hours, which provide instructions regarding how enrollees may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

28 CCR 1300.67.2.2. (c)(10)
(c) Standards for Timely Access to Care.
(10) Plans shall ensure that, during normal business hours, the waiting time for an enrollee to speak by telephone with a plan customer service representative knowledgeable and competent regarding the enrollee's questions and concerns shall not exceed ten minutes.

28 CCR 1300.67.2.2. (d)(1)
(d) Quality Assurance Processes. Each plan shall have written quality assurance systems, policies and procedures designed to ensure that the plan's provider network is sufficient to provide accessibility, availability and continuity of covered health care services as required by the Act and this section. In addition to the requirements established by Section 1300.70 of Title 28, a plan's quality assurance program shall address:

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(1) Standards for the provision of covered services in a timely manner consistent with the requirements of this section.

28 CCR 1300.80 (b)(5)(D)
(b) The onsite medical survey of a plan shall include, but not be limited to, the following procedures to the extent considered necessary based upon prior experience with the plan and in accordance with the procedures and standards developed by the Department.
(5) Review of the overall performance of the plan in providing health care benefits, by consideration of the following:
(D) The practice of health professionals and allied personnel in a functionally integrated manner, including the extent of shared responsibility for patient care and coordinated use of equipment, medical records and other facilities and services;

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Dental Director
- QM Director
- Provider Relations Manager

DOCUMENTS TO BE REVIEWED

- Policies and procedures defining standards for hours of operation
- Policies and procedures for monitoring of the standards for hours of operation
- Policies and procedures defining standards for after-hours coverage requirements
- Policies and procedures for monitoring of the standards for after-hours care;
- Plan after-hours coverage and access monitoring reports, after-hours or other types of telephone access studies from the Plan's telephone system or other methodologies (such as random calling at various times and dates)
- Committee Meeting minutes (of any/all appropriate committees)
- Provider Manual or other methods to communicate standards to providers
- Corrective Action Plans
- Review licensing filing of the Plan's Access standards and confirm submission of appropriate policies and procedures.

Key Element 1:

1. **The Plan has established a standard defining reasonable hours of operation for provider health care facilities that are sufficient to prevent delays detrimental to the health of enrollees.**
   28 CCR 1300.67.2 (b) and (d); 28 CCR 1300.67.2.2. (c)(1); 28 CCR 1300.67.2.2. (c)(7); 28 CCR 1300.67.2.2 (c)(10)

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Assessment Questions	Yes	No	N/A
1.1 Does the Plan have an established standard that defines reasonable hours of operation for provider facilities?			
1.2 Does the standard ensure that availability is sufficient to prevent delays detrimental to the health of enrollees?			
1.3 Does the Plan assist enrollees to contracted neighboring service areas when there is a shortage of primary dentists in a particular area?			
1.4 Does the Plan arrange for specialty care outside the network if medically necessary for the enrollee?			

Key Element 2:

2. The Plan has established standards that ensure that the availability of and access to after-hours services both at the Plan and provider-level are sufficient to prevent delays detrimental to the health of enrollees.
28 CCR 1300.67.2 (b) and (d); 28 CCR 1300.67.2.2. (c)(7); 28 CCR 1300.67.2.2. (c)(9)

Assessment Questions	Yes	No	N/A
2.1 Does the Plan have established standards on availability of and access to after-hours services which address provider message/answering service requirements?			
2.2 Does the Plan have established standards on availability of and access to after-hours services which address availability of providers?			
2.3 Does the Plan have established standards on availability of and access to after-hours services which address provider response to messages left after hours?			
2.4 Does the Plan have established standards on availability of and access to after-hours services which address Plan services (e.g., customer service)?			
2.5 Do the standards ensure that availability of an access to after-hours services is sufficient to prevent delays detrimental to the health of enrollees?			
2.6 Does the Plan ensure that contracted providers employ an answering service or telephone answering machine during non-business hours?			
2.7 Does the answering service, or answering machine used during non-business hours provide instructions regarding: (a) How enrollees may obtain urgent or emergency care? (b) How to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care?			

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Key Element 3:

3. The Plan has established and implemented a documented system for monitoring and evaluating providers' adherence to the standards regarding hours of operation and after-hours services.
28 CCR 1300.67.2 (b) and (d); 28 CCR 1300.67.2 (f); 28 CCR 1300.67.2.2 (d)(1)

Assessment Questions	Yes	No	N/A
3.1 Has the Plan established standards for the provision of covered services in a timely manner?			
3.2 Does the Plan disseminate its standard to providers (e.g., via provider contracts, provider manual, etc.)?			
3.3 Does the Plan regularly measure providers' performance against its standard?			
3.4 Does the Plan implement corrective action and follow-up review to address any deficiencies?			
3. 5 Does the Plan periodically review the appropriateness of its standard and update it when indicated?			

End of Requirement AA-003: Hours of Operation and After Hours Service

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Requirement AA-004: Appointment Availability

STATUTORY/REGULATORY CITATIONS

28 CCR 1300.51 (d)(I)(5)(d) and (e)
(d) Exhibits to Plan Application.
I. Description of Health Care Arrangements.
Note: Providers of Health Care Services. The information in this item is for the purpose of assessing the adequacy of the applicant's health care provider arrangements.
If the service area of the plan and the distribution of its enrollees is so geographically limited that all plan health care providers are readily available and accessible to all enrollees, no geographic division of the provider information required in this part need be made.
However, if applicant's service area is divided into separate provider networks for regions within the service area, the information required in this Item-1 must be furnished separately for each such region and provider network.
5. Applicants Standards of Accessibility. Attach as Exhibit I-5 a detailed description of the applicant's standards with respect to the accessibility and its procedures from monitoring the accessibility of services. Standards should be expressed in terms of the level of accessibility, which the applicant has as its objective, and minimum level of accessibility below which corrective action will be taken. Cover each of the following:
d. the proximity of specialists, hospitals, etc. to sources of primary care, and
e. a description of applicant's system for monitoring and evaluating accessibility.

28 CCR 1300.51 (d)(H)(iv)
(d) Exhibits to Plan Application.
H. Geographical Area Served.
Note: The applicant is required to demonstrate that, throughout the geographic regions designated as the plan's Service Area, a comprehensive range of primary, specialty, institutional and ancillary services are readily available at reasonable times to all enrollees and, to the extent feasible, that all services are readily accessible to all enrollees.
For the purpose of evaluating the geographic aspects of availability and accessibility, consideration will be given to the actual and projected enrollment of the plan based on the residence and place of work of enrollees within and, if applicable, outside the service area, including the individual and group enrollment projections furnished in Items CC, DD and EE of this application.
An applicant for plan license must demonstrate compliance with the accessibility requirement in each of the areas specified in paragraphs (i) through (iv) below, either by demonstrating compliance with the guideline specified in such paragraphs or, in the alternative, by presenting other information demonstrating compliance with reasonable accessibility. These guidelines apply only with respect to initial license applications and provide presumptively reasonable standards in the absence of actual operating experience. Such guidelines are not intended to express minimum standards of accessibility either for applicants or for licensees nor to create any

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inference that a plan, which does not meet these guidelines, does not meet the requirement of reasonable accessibility.
(iv) Ancillary Services. Ancillary laboratory, pharmacy and similar services and goods dispensed by order or prescription on the primary care provider are available from contracting or plan-operated providers at locations (where enrollees are personally served) within a reasonable distance from the primary care provider.

28 CCR 1300.67.1 (a), (d), and (e)
Within each service area of a plan, basic health care services shall be provided in a manner, which provides continuity of care, including but not limited to:
(d) The maintenance of staff, including health professionals, administrative and other supporting staff, directly or through an adequate referral system, sufficient to assure that health care services will be provided on a timely and appropriate basis to enrollees;
(e) An adequate system of documentation of referrals to physicians or other health professionals. The monitoring of the follow up of enrollees' health care documentation shall be the responsibility of the health care service plan and associated health professionals.

28 CCR 1300.67.2 (e) and (f)
Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees;
(e) A plan shall provide accessibility to medically required specialists who are certified or eligible for certification by the appropriate specialty board, through staffing, contracting, or referral;
(f) Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments.

28 CCR 1300.67.2.2. (c)(3), (4), and (6)
(c) Standards for Timely Access to Care.
(3) When it is necessary for a provider or an enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice, and consistent with the objectives of Section 1367.03 of the Act and the requirements of this section.
(4) Interpreter services required by Section 1367.04 of the Act and Section 1300.67.04 of Title 28 shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment. This subsection does not modify the requirements established in Section 1300.67.04, or approved by the Department pursuant to Section 1300.67.04 for a plan's language assistance program.
(6) In addition to ensuring compliance with the clinical appropriateness standard set forth at subsection (c)(1), each dental plan, and each full service plan offering coverage for dental services, shall ensure that contracted dental provider networks have adequate capacity and availability of licensed health care providers to offer enrollees appointments for covered dental services in accordance with the following requirements:

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A) Urgent appointments within the dental plan network shall be offered within 72 hours of the time of request for appointment, when consistent with the enrollee's individual needs and as required by professionally recognized standards of dental practice;
(B) Non-urgent appointments shall be offered within 36 business days of the request for appointment, except as provided in subsection (c)(6)(C); and
(C) Preventive dental care appointments shall be offered within 40 business days of the request for appointment.

28 CCR 1300.67.2.2. (c)(6)
(6) In addition to ensuring compliance with the clinical appropriateness standard set forth at subsection (c)(1), each dental plan, and each full service plan offering coverage for dental services, shall ensure that contracted dental provider networks have adequate capacity and availability of licensed health care providers to offer enrollees appointments for covered dental services in accordance with the following requirements:
(A) Urgent appointments within the dental plan network shall be offered within 72 hours of the time of request for appointment, when consistent with the enrollee's individual needs and as required by professionally recognized standards of dental practice;
(B) Non-urgent appointments shall be offered within 36 business days of the request for appointment, except as provided in subsection (c)(6)(C); and
(C) Preventive dental care appointments shall be offered within 40 business days of the request for appointment.

28 CCR 1300.67.2.2. (d)(1)
(d) Quality Assurance Processes. Each plan shall have written quality assurance systems, policies and procedures designed to ensure that the plan’s provider network is sufficient to provide accessibility, availability and continuity of covered health care services as required by the Act and this section. In addition to the requirements established by Section 1300.70 of Title 28, a plan’s quality assurance program shall address:
(1) Standards for the provision of covered services in a timely manner consistent with the requirements of this section.

28 CCR 1300.70 (b)(2)(G)(5)
(b) Quality Assurance Program Structure and Requirements.
(2) Program Requirements.
(G) Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees.
If QA activities are delegated to a participating provider to ensure that each provider has the capability to perform effective quality assurance activities, the plan must do the following:
In order to meet these obligations each plan's QA program shall meet all of the following requirements:
(5)Ensure that for each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of

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timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the plan and/or delegated providers.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- QM Director
- Director of Provider Relations
- Director of Network Management or its equivalent

DOCUMENTS TO BE REVIEWED

- Policies and procedures that define appointment availability
- Policies and procedures that address re-scheduling of appointments
- Appointment availability studies
- Enrollee and provider satisfaction surveys
- Reports on complaint and grievances
- Telephone access studies from the Plan's telephone system or other methodologies (such as anonymous "mystery shopper" or random calling at various times and dates)
- Committee or applicable subcommittee minutes, prior two years
- Corrective action plans and re-measurement of appointment availability to assure improvements are sustained
- Review licensing filing of the Plan's Access standards and confirm submission of appropriate policies and procedures.

Key Element 1:

1. The Plan ensures that contracted dental provider networks have adequate capacity and availability of licensed health care providers to offer enrollees appointments for covered dental service in accordance with requirements.
   28 CCR 1300.67.2.2. (c)(6)

Assessment Questions	Yes	No	N/A
1.1 Are urgent appointments within the dental plan network offered within 72 hours of the time of request?			
1.2 Are non-urgent appointments offered within 36 business days of the request for appointment?			
1.3 Are preventive dental care appointments offered within 40 business days of the request for appointment?			

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Key Element 2:

2. Each health care service Plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments. 28 CCR 1300.51 (d)(I)(5)(d); 28 CCR 1300.51 (d)(H)(iv); 28 CCR 1300.67.1 (a), (d) and (e); 28 CCR 1300.67.2 (e) and (f); 28 CCR 1300.67.2.2. (c)(3), (4), and (6); 28 CCR 1300.67.2.2. (d)(1)

Assessment Questions	Yes	No	N/A
2.1 Does the health Plan have a documented system of monitoring and evaluating access to care, including waiting time and appointments consistent with time elapsed standards noted in Key Element 1?			
2.2 Does the documented system for monitoring and evaluating access to care include **urgent** appointments?			
2.3 Does the documented system for monitoring and evaluating access to care include **non-urgent** appointments?			
2.4 Does the documented system for monitoring and evaluating access to care include **preventive** dental care appointments?			
2.5 Does the documented system for monitoring and evaluating include rescheduling of appointments to ensure rescheduling is prompt and consistent with health care needs, continuity of care?			
2.6 Does the Plan monitor coordination of language interpreters with scheduled appointments?			
2.7 Does the Plan monitor to ensure providers use an answering service or telephone answering machine during non-business hours?			
2.8 Does the Plan monitor to ensure the answering service provides instructions regarding how enrollees may obtain urgent or emergency care?			
2.9 Does the Plan monitor to ensure the answering service provides information, when applicable, how to contact another provider who has agreed to be on call to triage or screen by phone, or if needed, deliver urgent or emergency care?			
2.10 Does the Plan monitor performance against the standards?			
2.11 Does the Plan monitor telephone service accessibility?			
2.12 Does the Plan evaluate network capacity to ensure that its contracted provider network has the adequate capacity and availability of licensed provider to offer enrollees appointments that meet time elapsed standards?			
2.13 When the Plan identifies problems, does it take action to ensure appointment availability?			
2.14 When the Plan identifies problems, does it monitor to assure improvements are maintained?			

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End of Requirement AA-004: Appointment Availability

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Requirement AA: 005 Enrollee Health Education

STATUTORY/REGULATORY CITATIONS

28 CCR 1300.67.2 (g)
A section of the health education program shall be designated to inform enrollees regarding accessibility of service in accordance with the needs of such enrollees for such information regarding that Plan or area.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Supervisor or Manager of Health Education or equivalent
- QM Director
- Director or Manager of Customer Relations or Member Services

DOCUMENTS TO BE REVIEWED

- Policies and procedures of the Health Education Program
- Health Education Program description
- Plan and delegate Web sites
- Patient education materials regarding the accessibility of service (e.g., certificate of coverage member handbook);
- Plan review of delegated entities' Health Education Programs and notification to enrollees of how to access services

Key Element 1:

1. **The Plan regularly distributes materials to each enrollee that explain how to obtain services.**
   28 CCR 1300.67.2 (g)

Assessment Questions	Yes	No	N/A
1.1 Has the Plan developed materials that explain how to obtain **primary** dental care services?			
1.2 Has the Plan developed materials that explain how to obtain **specialty** dental care services?			
1.3 Has the Plan developed materials that explain how to obtain **after-hours** care?			
1.4 Has the Plan developed materials that explain how to obtain **urgent**			

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care?			
1.5 Has the Plan developed materials that explain how to obtain **emergency** care?			
1.6 Does the Plan regularly distribute the materials to enrollees?			

Key Element 2:

2. The Plan ensures that delegated entities inform enrollees how to access services. 28 CCR 1300.67.2 (g)

Assessment Questions	**Yes**	**No**	**N/A**
2.1 Does the Plan ensure that delegated entities inform enrollees how to obtain (as applicable to the delegate's responsibilities) **primary** dental care services?			
2.2 Does the Plan ensure that delegated entities inform enrollees how to obtain (as applicable to the delegate's responsibilities) **specialty** care services?			
2.3 Does the Plan ensure that delegated entities inform enrollees how to obtain (as applicable to the delegate's responsibilities) **after-hours** care?			
2.4 Does the Plan ensure that delegated entities inform enrollees how to obtain (as applicable to the delegate's responsibilities) **urgent** care?			
2.5 Does the Plan ensure that delegated entities inform enrollees how to obtain (as applicable to the delegate's responsibilities) **emergency** care?			

End of Requirement AA-005: Enrollee Health Education

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Requirement AA-006: Preventive Health Care (formerly QM-005)

STATUTORY/REGULATORY CITATIONS

28 CCR 1300.67 (f)
Preventive health services (including services for the detection of asymptomatic diseases), which shall include, under a Web site's supervision,
(1) Reasonable health appraisal examinations on a periodic basis;
(2) A variety of voluntary family planning services;
(3) Prenatal care;
(4) Vision and hearing testing for persons through age 16;
(5) Immunizations for children in accordance with the recommendations of the American Academy of Pediatrics and immunizations for adults as recommended by the U.S. Public Health Service;
(6) Venereal disease tests;
(7) Cytology examinations on a reasonable periodic basis;
(8) Effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the plan or health care organizations affiliated with the plan.

28 CCR 1300.67 (f)(8)
(f) Preventive health services (including services for the detection of asymptomatic diseases), which shall include, under a physician's supervision,
(8) Effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the plan or health care organizations affiliated with the plan.

28 CCR 1300.67.2 (f)
(f) Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments.

28 CCR 1300.70 (b)(2)(G)(5) and (6) *(Applicable to delegated groups only)*
(b) Quality Assurance Program Structure and Requirements.
(2) Program Requirements.
In order to meet these obligations each plan's QA program shall meet all of the following requirements:
(G) Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees.
If QA activities are delegated to a participating provider to ensure that each provider has the capability to perform effective quality assurance activities, the plan must do the following:

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(5) Ensure that for each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the plan and/or delegated providers.
(6) Ensure that health services include appropriate preventive health care measures consistent with professionally recognized standards of practice. There should be screening for conditions when professionally recognized standards of practice indicate that screening should be done.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Dental Director
- QA Director
- QA Coordinator

DOCUMENTS TO BE REVIEWED

- Policies and procedures ensuring provision of preventive care services
- Preventive care guidelines
- Minutes of QA Committee or subcommittee meetings
- Provider Manual
- Health education literature
- Provider education and informational materials
- Results of measurement of other preventive health guidelines
- List of preventive care objectives with associated tracking reports

Key Element 1:

1. **The Plan has established preventive care guidelines. The Plan has disseminated its guidelines to its providers, regularly monitors performance against the standards and addresses any deficiencies.**
   28 CCR 1300.67 (f); 28 CCR 1300.67.2 (f)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have established preventive guidelines?			
1.2 Does the Plan use appropriate methods in developing or adopting preventive guidelines?			
1.3 Are the guidelines comprehensive?			
1.4 Does the Plan have an effective mechanism for distributing its guidelines to participating providers?			
1.5 Does the Plan monitor the provision of preventive services on an			

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	individual and plan-wide basis?			
1.6	Does the Plan regularly measure the level of preventive care provided to enrollees against its established guidelines?			
1.7	Does the Plan critically evaluate the results of preventive care monitoring?			
1.8	Does the Plan **develop and implement** corrective actions or QM Programs with measurable goals to increase levels of preventive care for enrollees?			
1.9	Does the Plan re-**measure and critically evaluate** the results of corrective actions or QM Programs to increase levels of preventive care for enrollees?			
1.10	Does the Plan develop and implement additional corrective actions or QM Programs based on the critical evaluation of its past corrective actions or QM Programs?			

Key Element 2:

2. The Plan has an effective Health Education Program designed to educate enrollees regarding personal health behavior and health care, including recommendations regarding the optimal use of health care services provided by the Plan or health care organizations affiliated with the Plan.
28 CCR 1300.67 (f)(8)

Assessment Question		Yes	No	N/A
2.1	Does the Plan have effective preventive health education services that include information regarding personal health behavior and optimal use of preventive services provided under the Plan?			

End of Requirement AA-006: Preventive Health Care

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Requirement AA-007: List of Contracting Providers Available Upon Request

STATUTORY/REGULATORY CITATIONS

CA Health and Safety Code section 1367.26
(a) A health care service plan shall provide, upon request, a list of the following contracting providers, within the enrollee's or prospective enrollee's general geographic area:
(1) Primary care providers.
(2) Medical groups.
(3) Independent practice associations.
(4) Hospitals.
(5) All other available contracting physicians, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, and nurse midwives to the extent their services may be accessed and are covered through the contract with the plan.
(b) This list shall indicate which providers have notified the plan that they have closed practices or are otherwise not accepting new patients at that time.
(c) The list shall indicate that it is subject to change without notice and shall provide a telephone number that enrollees can contact to obtain information regarding a particular provider. This information shall include whether or not that provider has indicated that he or she is accepting new patients.
(d) A health care service plan shall provide this information in written form to its enrollees or prospective enrollees upon request. A plan may, with the permission of the enrollee, satisfy the requirements of this section by directing the enrollee or prospective enrollee to the plan's provider listings on its website. Plans shall ensure that the information provided is updated at least quarterly. A plan may satisfy this update requirement by providing an insert or addendum to any existing provider listing. This requirement shall not mandate a complete republishing of a plan's provider directory.
(e) Each plan shall make information available, upon request, concerning a contracting provider's professional degree, board certifications and any recognized subspeciality qualifications a specialist may have.
(f) Nothing in this section shall prohibit a plan from requiring its contracting providers, contracting provider groups, or contracting specialized health care plans to satisfy these requirements. If a plan delegates the responsibility of complying with this section to its contracting providers, contracting provider groups, or contracting specialized health care plans, the plan shall ensure that the requirements of this section are met.
(g) Every health care service plan shall allow enrollees to request the information required by this section through their toll-free telephone number or in writing.

CA Health and Safety Code section 1367.26 (d)
(d) A health care service plan shall provide this information in written form to its enrollees or prospective enrollees upon request. A plan may, with the permission of the enrollee, satisfy the requirements of this section by directing the enrollee or prospective enrollee to the plan's

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provider listings on its website. Plans shall ensure that the information provided is updated at least quarterly. A plan may satisfy this update requirement by providing an insert or addendum to any existing provider listing. This requirement shall not mandate a complete republishing of a plan's provider directory.

CA Health and Safety Code section 1367.26 (e) and (g)
(e) Each plan shall make information available, upon request, concerning a contracting provider's professional degree, board certifications and any recognized subspeciality qualifications a specialist may have.
(g) Every health care service plan shall allow enrollees to request the information required by this section through their toll-free telephone number or in writing.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Dental Director
- Director of Contracting / Provider Relations
- Director of QM

DOCUMENTS TO BE REVIEWED

- Plan Provider Directory
- Electronic version of the Plan's Provider Directory and the Plan's online Provider Directory
- Any available updates to the Plan Provider Directory.
- Policies and procedures relevant to the update of contact information for contracted providers.
- Previous versions of the Plan Provider Directory that show that modifications have been made, where needed.
- Documents and correspondence between the Plan and contracted providers that indicate any changes to the provider's contact information.

Key Element 1:

1. The Plan has a complete list of contracted providers that includes all required information.
CA Health and Safety Code section 1367.26

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have a list of all of its contracted providers?			
1.2 Does the Plan maintain records of each provider's professional degree,			

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	board certifications, and any recognized subspecialty qualifications that a specialist may have?			
1.3	Does the Plan's list of contracted providers indicate which providers have notified the plan that they have closed practices?			
1.4	Does the Plan's list of contracted providers indicate which providers are not accepting new patients at this time?			
1.5	Does the Plan's list of contracted providers indicate that the list is subject to change without notice?			
1.6	Does the Plan's list of contracted providers include a telephone number that enrollees can contact to obtain information regarding a particular provider, including whether or not that provider is accepting new patients?			

GUIDANCE

- The Plan may delegate these duties, but it must still ensure that the requirements of this section are met.

COMMENTS

Key Element 2:

2. The Plan properly updates its list of contracted providers.
CA Health and Safety Code section 1367.26 (d)

Assessment Questions		Yes	No	N/A
2.1	Does the Plan either: a) provide the provider list in written form to its enrollees and prospective enrollees upon request or, b) with the permission of the enrollee or prospective enrollee, refer the inquiry to the Plan's Web site?			
2.2	Does the Plan have policies and procedures that ensure that all of the information contained in its provider directory is updated quarterly?			

GUIDANCE

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- The Plan may delegate these duties, but it must still ensure that the requirements of this section are met.
- A Plan may satisfy the provider directory update process by republishing or inserting an addendum into the existing printed version of the provider directory.
- The Plan should attempt to take some active steps, such as sending a mass mailing to providers requesting updated information, which would ensure that the Plan's information is up to date.

COMMENTS

Key Element 3:

3. The Plan provides provider information to its enrollees upon telephone or written request.
CA Health and Safety Code section 1367.26 (e) and (g)

Assessment Questions	**Yes**	**No**	**N/A**
3.1 Does the Plan provide enrollees and prospective enrollees with provider information through their toll-free telephone number or in writing?			
3.2 Does the Plan provide information to enrollees and prospective enrollees about each provider's professional degree, board certifications, and any recognized sub-specialty qualifications that a sub-specialist may have?			

GUIDANCE

- The Plan may delegate these duties, but it must still ensure that the requirements of this section are met.

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COMMENTS

End of Requirement AA-007: List of Contracting Providers Available Upon Request